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STATE OF LOUISIANA
Office of Worker's Compensation Administration
P.O. Box 94040
Baton Rouge, LA 70804-9040
(504) 342-7555
Toll Free 1-800-824-4592

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

Injured's Social Security Number

Employer's UC Reporting Number

Employer's Federal ID Number

Agency FACS Cost Ctr No./Loc. Code

DATES

1. Date of Report MM/DD/YY
2. Date of Injury and Time MM/DD/YY Time: ☐ AM ☐ PM
3. Normal Starting Time Day of Accident Time: ☐ AM ☐ PM
4. If Employee Back to Work Give Date: MM/DD/YY
   At Same Wage? ☐ Yes ☐ No
6. If Fatal Injury, Give Date of Death: MM/DD/YY
7. Date Employer Knew of Injury MM/DD/YY
8. Date Lost Time Began MM/DD/YY
9. Last Full Day Paid - Date MM/DD/YY

DO NOT WRITE IN THIS COLUMN

Date Received

EMPLOYEE

10. Employee: First Middle Last
11. ☐ Male ☐ Female
12. Employee Telephone Number (Include Area Code)
13. Address-Include Parish and Zip Code
14. Race ☐ White ☐ Black ☐ Amer. Indian ☐ Asian ☐ Other
15. ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
16. Number of Children Under 18
17. Date of Hire MM/DD/YY
    No. Yrs. Service
18. Present Age
19. Occupation/C.S. Code No.
20. Department or Division Regularly Employed
21. Employees Date of Birth MM/DD/YY

S.I.C.

State-Parish

Occupation

Nature of Injury

OCCURRENCE

22. Place of Injury - Employer's Premises ☐ Yes ☐ No
23. If No, Exact Location - Street, City, Parish, and State
24. What Was the Employee Doing When Injured? *(Be specific. If using tools or equipment or handling material - Name them and tell what he was doing with them)*
25. How Did Injury Occur? *(Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to injury or disease.)*

Names and work phone numbers of all witnesses:

Did Injury or Disease Occur Because of:
26. Mechanical defect ☐ Yes ☐ No *(Describe Above)*
27. Unsafe Act ☐ Yes ☐ No *(Describe Above)*
28. CHECK IF AMPUTATION ☐
29. Nature and Location of Injury or Disease *(Describe Fully, Include Parts of Body Affected)*
30. OCC Disease - Date of Initial Diagn.
31. Attending Physician and Address (If Hospital Involved Indicate)

Part of Body

Source of Injury

Type of Accident

Insurance Code

A.O.S.

Unsafe Act

Agency of Acc.

Agency of Acc. Part

Hazardous Conditions

EMPLOYER

32. Employer
33. Person Making Out This Report
34. Address - Include Parish and Zip Code (Physical Location to include street, city, etc.)
35. Employer Telephone Number (Include Area Code)
36. Mailing Address - If Different Than Above
37. Nature of Business - Type of Mfg., Trade, Construction, Service, etc.

1. Purpose of This Report
   - ☐ More than 7 days of disability
   - ☐ Injury resulted in death
   - ☐ Amputation or Disfigurement
   - ☐ Medical Only
   - ☐ Possible Dispute
2. Check whether this is change of status from original notice sent to insurance carrier:
   Yes ☐ No ☐
   If yes, date disability began _____
   Date employee returned to work _____
   At same wage? Yes ☐ No ☐

Return Original Copy To:
STATE OF LOUISIANA
OFFICE OF RISK MANAGEMENT
P.O. Box 94095 —Capitol Station
Baton Rouge, La. 70804-9095

WAGE INFORMATION In the event of permanent disability, death, or disability beyond the 7-day waiting period, wages must be provided:
Fixed Wage: $ _____ Hourly $ _____ Monthly $ _____ Annual $ _____ Other
If the amount entered is "Hourly" or "Other" fill out the appropriate section below:

Hourly:
If "Hourly" and employee worked 40 hours per week or more, show the hours worked in the four full weeks preceding the date of accident. Hours _____
If "Hourly" and employee worked less than 40 hours per week, show the average total earnings per week for the four full weeks preceding the date of accident. $ _____
If "Hourly" and employee is part-time, show the average hours worked in four full weeks preceding the date of accident. Hours _____

Other:
If "Other" and employee worked for a 26 week period or more, show the gross earnings in the 26 week period immediately preceding the accident and the number of days the employee worked for the employer during that same 26 week period. $ _____ Days _____

If "Other" and employee worked less than 26 weeks, show the gross earnings in the period immediately preceding the accident and the number of days the employee worked for the employer during that period. $ _____ Days _____